B A N G L A D E S H

Nutritional Surveillance Project

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Nutrition, Health and Poverty in Bangladesh in 2001: Facilitating Action through Data Sharing

Governments and development organizations throughout the world recognize that poverty alleviation should be the principal concern of development efforts. Many have pledged their support for the Millennium Development Goals (MDG) which set targets for reducing poverty and related social imbalances from 1990 to 2015. Malnutrition contributes to poverty because it impairs development in children, and health and work productivity in all. Polices and programs to improve nutritional status are therefore key to alleviating poverty and achieving the MDG in countries such as Bangladesh, where malnutrition is rife. Since its inception in 1990, the HKI/IPHN Nutritional Surveillance Project has provided stakeholders with detailed information needed to advocate for, design, monitor and evaluate policies and programs covering many development concerns in Bangladesh, including health, nutrition, food security, gender disparities, and poverty. This bulletin provides a summary of the NSP findings[a] for rural areas and urban slums in Bangladesh in 2001 and proposes priority actions.

Rural Bangladesh

The NSP recorded substantial improvements in child nutritional status in rural Bangladesh during the last decade, and surveillance in 2001 has shown that these trends have continued. Between 1991 and 2001, there was a steady decline in the prevalence of stunting from 71% to 50% and underweight from 71% to 57% among children aged 6-59 mo. Although these findings are encouraging, the rate of improvement during the 1990s was far below the goals of the 1990 World Summit for Children.[1] Furthermore, the prevalence of child stunting and underweight in 2001 are still 'very high' according to criteria of the [World Health Organization][2], and are higher than the average prevalence for South Asia and other regions of the developing world.[3] In fact, Bangladesh has the highest prevalence of child underweight of all countries in the world except North Korea, and only seven countries have a higher prevalence of child stunting.[3]

Maternal wasting is also extremely common (35-41%), and indicates that the household food security situation is 'serious' or 'critical'[3] throughout the year. Elsewhere in the world, these grades of household food insecurity are usually only reported during emergency situations such as famine and war. About 4.5 million rural households or 24 million people (24% of the rural population) have an energy intake <1805 kcal/person/d, an indicator of 'extreme' poverty, and a similar number have an intake of 1805-2122 kcal/person/d, an indicator of 'moderate' poverty.[4]

Almost one-half of children (47%) and one-third of non-pregnant mothers (33%) are anemic, which is largely due to iron deficiency. Coverage of the vitamin A capsule program among children aged 12-59 mo is very high (96-97%), and the prevalence of nightblindness in children is below the 1% threshold that indicates a public health problem. However, the high prevalence of anemia and stunting indicate that dietary intake of micronutrients, including iron and vitamin

[a]Information on how data are collected and analyzed is provided in the bulletins and on the CDROM.

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A, is still very low. The rural diet is still not very diversified and only a small percentage of households regularly consume animal foods, vegetables and other good sources of micronutrients.

The findings presented in the rural bulletins indicate that the nutrition situation is not homogenous across all divisions of the country. This variation reflects differences between the divisions in a number of factors relevant to nutrition and poverty, including the opportunities for sustainable and productive livelihoods in agriculture, industry and the public and informal sectors, vulnerability to natural disasters, provision of basic services by the government, and participation by households in NGO activities.

Urban slums

An alarming rise in urban poverty is occurring alongside rapid urbanization in Bangladesh. The NSP collects data from selected urban slums in the three largest cities, Dhaka, Chittagong and Khulna. These slums grew by 67%[5,a] between 1986 and 1997, compared with an overall growth of 38% in the urban population and 10% in the rural population in the 1990s. Living conditions, food security, health and nutrition vary considerably between slums within the same city as well as between poor urban communities in different cities. Nevertheless, it is clear that widespread poverty, poor health and malnutrition are common to all and that the problems are of similar magnitude as in rural Bangladesh, if not worse.

Despite rapid urbanization, and the immense pressure on urban infrastructure and services, data collected in the NSP urban slum sites show that the nutritional status of children improved during the last decade. Between 1991 and 2001, there was a steady decline in the prevalence of stunting from 72-80% to 54-61% and underweight from 72-83% to 51-68% among children aged 6-59 mo. However, the prevalence of both is still 'very high' in all three urban sites, and the rapid population growth of the urban slums means that the number of undernourished children is rising even if the prevalence is declining. The most alarming finding was the extremely high prevalence of wasting (low weight for height, an indicator of acute food shortage/illness) in children aged 0-23 mo in Chittagong slums, which was up to 35% in 2001, comparable with a severe famine situation and indicative that child mortality is likely to be very high.

The data on food security indicate that households in the urban slums, particularly in Chittagong and Khulna, face immense difficulties in obtaining food. One-half (50%) of the slum households in these two cities had an energy intake <1805 kcal/person/d, and a further 21-25% had an energy intake of 1805-2122 kcal/person/d. These findings indicate a far worse household food security situation than in any of the rural divisions.

The diet of households in the urban slums was slightly more diversified than in rural Bangladesh, but the high prevalence of stunting and extremely high prevalence of child anemia in children aged 6-59 mo recorded by an NSP survey in October 1999 (71-90%) suggest that the diet does not contain sufficient iron and other micronutrients. As in rural Bangladesh, coverage of the vitamin A capsule (VAC) program was very high (98-100%), and the prevalence of nightblindness in children was below the 1% threshold that indicates a public health problem.

What needs to be done?

The relatively slow decline in the prevalence of malnutrition in Bangladesh in the 1990s suggests that past approaches to improving nutritional status have not been sufficiently effective. The magnitude of the problem and its implications for the health and survival of children and mothers, as well as the social and economic development of the country, demand that better progress is made in the coming decade.

Direct nutrition interventions are needed to assist those affected by malnutrition, including nutritional rehabilitation and direct feeding programs for the severely malnourished; micronutrient supplementation to prevent and control micronutrient deficiencies among those at highest risk, particularly young children and women; and food fortification to improve the micronutrient status of the population as a whole. Distribution of vitamin A capsules during the twice-yearly polio National Immunization Days (NIDs) has achieved excellent coverage, but alternative strategies need to be developed to sustain the high coverage when the polio NIDs become annual in 2003 and are discontinued after 2005. VAC coverage should also be expanded to include children aged 6-11 mo, who are also at risk of vitamin A deficiency. Iron or multi-micronutrient supplements should be used to combat the high prevalence of

[a] Slum population of the statistical metropolitan area

anemia in children and mothers because foods naturally rich in iron cannot bridge the current gap between needs and intake, and fortified foods are not yet widely available or affordable. Health and nutrition education also has an important role, although research has shown that households make some changes in their behavior even without education once they have access to the necessary resources.

The Government of Bangladesh recognizes the serious nature of the nutrition problems in the country and its devastating consequences for the nation, and has therefore integrated many of the above mentioned direct nutrition interventions into its programs, including the Health and Nutrition Population Sectoral Program, planned for 2003-2006, and the National Nutrition Program (NNP), which works through NGOs to deliver community-based nutrition services. The major challenge of both programs will be to ensure that the activities are managed and implemented effectively, rigorously monitored and evaluated, and refined where necessary.

Actions are also needed to address the underlying causes of malnutrition, particularly household food insecurity. Bangladesh is almost self-sufficient in rice production, but the availability of other foods, including pulses, vegetables and animal products, which are essential sources of fat, protein and micronutrients, is inadequate. There is a severe shortage of employment in rural areas and the urban slums, and the bulk of the population is too poor to afford a nutritious diet. While the NNP includes a component to improve household food security, there is a crucial need to ensure that all other nutrition, food, agriculture and development policies and programs place a far greater emphasis on improving household food security. Interventions should focus on diversifying crop production, promoting homestead food production, creating better employment opportunities, improving access to credit, and targeting food assistance to the poorest households. Infectious diseases such as diarrhea are still a major cause of malnutrition, and so households need a sanitary environment and better access to preventive and curative health services.

Labor-intensive economic growth, sound macro-economic management and good governance are essential for generating employment and income for the poor so that they have more money to spend on food. These strategies can reduce poverty and malnutrition when coupled with comprehensive policies and programs for social development that provide basic services to the poor, such as health care services, water and sanitation, education and skills development. Attention must also be given to removing gender inequities and to improving women's status in society. Leaders in developed countries and other international players have a crucial role in ensuring that their policies on global trade provide better access of exports from Bangladesh to international markets.

With the numbers of urban poor expected to reach 23 million by 2010[6], the scale of urban poverty has become a critical policy issue. There is increasing need to design and implement effective policies and programs that address the specific needs of poor slum residents. Overarching needs are the provision and expansion of basic social services, improved urban infrastructure, and better employment and income-earning opportunities in both the formal and non-formal sectors.

Advocacy is necessary at all levels to increase awareness and to create the political will to combat malnutrition and hence poverty. Nutrition and health surveillance generates the data needed to formulate powerful evidence-based advocacy material and to stimulate action. With sustained support, the NSP will continue to provide donors and development agencies with high quality information on the magnitude and determinants of undernutrition in Bangladesh to help establish priorities for policies and programs. The NSP can also monitor and evaluate policies and programs in nutrition, food security and poverty alleviation, including the impact of national nutrition programs such as the NNP, and will assess progress towards international targets for health, nutrition and poverty.

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Recommendations

- Direct nutrition interventions are needed to assist those affected by malnutrition, including nutritional rehabilitation and direct feeding programs for the severely malnourished; micronutrient supplementation to prevent and control anemia and vitamin A deficiency, particularly among young children and women; and food fortification to improve the micronutrient status of the population as a whole.
- All food, agriculture and development policies and programs should place greater emphasis on interventions to improve household food security, including crop diversification, homestead food production, employment and income creation, credit facilities, and food-based income transfers.
- Households also need a sanitary environment and better access to preventive and curative health services.
- These interventions should be complemented with poverty alleviation strategies that support labor-intensive economic growth, sound macroeconomic management, good governance and social development, including the empowerment of women, and global trade policies that stimulate the growth of Bangladesh's economy.
- Special attention is needed to address the specific needs of poor urban slum residents, particularly in the provision and expansion of basic social services, improved urban infrastructure, and better employment and income-earning opportunities.
- Nutrition and health surveillance should continue to provide the data needed to formulate advocacy material; to design, monitor and evaluate policies and interventions; and to track progress towards national and international targets for health, nutrition and poverty.

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